Boca Raton Counseling Center
BRIDGING THE GAP
4700 NW 2nd Avenue; Suite 401 Boca Raton, FL 33431 | TARA P: 561-948-3581 DUSTIN P:561.299.0304

INTAKE FORM

Name: _____

Address: _____

City, State & Zip: _____

Phone: _____Email_____

May we add you to our mailing list? Yes ___ No_____

Your D.O.B.: _____/_____/_____ Religion: _____ Gender: _____

Marital status: _____ Length of time in current relationship: _____

Spouse's name _____ Age _____ Quality of Rel. (1 low – 10 high) _____

What is your current occupation? _____

Place of employment: _____

How long at current position? _____ Do you enjoy what you do for a living? _____

Family Information When Applicable:

Mother's Name: _____ Age: _____ Quality of Rel. (1-10) _____

Father's Name: _____ Age: _____ Quality of Rel. (1-10) _____

Siblings – please list all brothers and sisters:

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Children:

Number of living children: _____ Number of pregnancies: _____ Sexually active? Y / N

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

Name: _____ Age: _____ Quality of Rel. (1-10) _____

History of mental health issues for you or your family: _____

History of substance abuse for your or your family: _____

History of sexual, physical or emotional abuse: _____

Have you ever attempted suicide? _____ Any current thoughts of suicide? _____

Do you have any medical concerns/conditions? _____

Are you currently taking any medications? Yes / No

Please list all medications: _____

Are you now or have you ever seen a psychiatrist? _____

Name and telephone of your primary physician: _____

May we contact your physician? _____

Emergency contact information (Name & Tel. #): _____

Have you experienced any losses or setbacks recently? If so, please explain: _____

_____

What brings you to counseling? _____

_____

Experience with previous counseling (inpatient/outpatient?):_____

_____

What are your goals for treatment? _____

_____

I hereby consent to be treated and have been informed of the limitations and risks:

_____ _____

Signature Date

Please note that a minimum of 24 hours notice is required for cancellations or rescheduling to avoid the full fee of $150 being due. _____ (Initial)

THANK YOU!